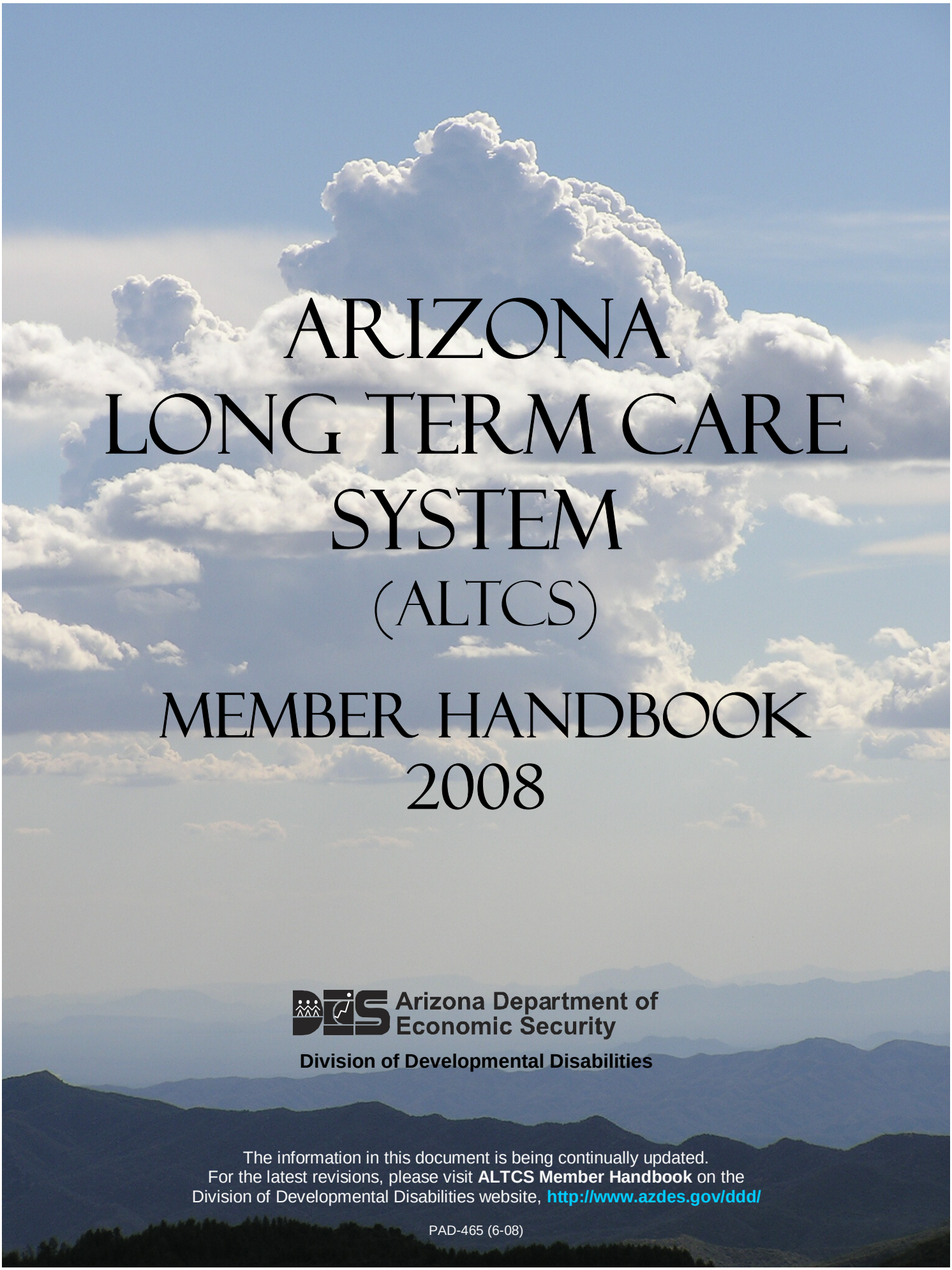

ARIZONA LONG TERM CARE SYSTEM (ALTCS)

MEMBER HANDBOOK 2008

Arizona Department of Economic Security

Division of Developmental Disabilities

The information in this document is being continually updated.
For the latest revisions, please visit **ALTCS Member Handbook** on the
Division of Developmental Disabilities website, **http://www.azdes.gov/ddd/**

PAD-465 (6-08)

ARIZONA LONG TERM CARE SYSTEM (ALTCS) MEMBER HANDBOOK

Division of Developmental Disabilities

Dear Member:

Welcome to the Arizona Long Term Care System (ALTCS). As a member you are qualified to receive services that are authorized by and funded through Title XIX (Medicaid) of the Social Security Act.

ALTCS services will be provided to you through the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). We are dedicated to working with you and your family to support meaningful choices that promote self-sufficiency, community involvement and health maintenance.

How the system works and what services are available are explained in this handbook. If you have any questions or need additional information, please contact your Support Coordinator or your local DES/DDD office.

Sincerely,

Tracy L. Wareing
Director
Department of Economic Security (DES)

Barbara Brent
Assistant Director (DES)
Division of Developmental Disabilities (DDD)

YOUR SUPPORT COORDINATOR

Name _____

Phone Number _____

All applicants for services and/or program participation have a right to file complaints and to appeal according to regulations by notifying:

Arizona Department of Economic Security
Director's Office of Equal Opportunity
1717 W. Jefferson Street, Room 109
Phoenix, AZ 85007
Voice: 602-364-3976 or TTY/TDD Services 7-1-1

Equal Opportunity Employer/Program ◆ Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-542-0419; TTY/TDD Services: 7-1-1.

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GENERAL INFORMATION

What is ALTCS?

ALTCS is the Arizona Long Term Care System that provides acute and long term care services under federal guidelines and federal funds.

The federal Medicaid Program contracts with the Arizona Health Care Cost Containment System (AHCCCS) to provide a managed care system, part of which is ALTCS. AHCCCS in turn contracts with the Department of Economic Security/ Division of Developmental Disabilities (DES/DDD) to deliver ALTCS services for eligible people with developmental disabilities. DES/DDD will be referred to as the Division throughout this booklet.

Who determines ALTCS eligibility?

AHCCCS determines eligibility based on your finances and on your medical and functional status. Continued eligibility is reviewed and determined by AHCCCS.

What happens after ALTCS eligibility is determined?

AHCCCS notifies the Division of your eligibility. Then a Division Support Coordinator will contact you or your responsible party. You will need to enroll with a health plan available in your county. You will also need to choose a Primary Care Provider (PCP). Please note that if you move after your enroll, you may have to change health plans and/or physicians. The Support Coordinator will help you with this. The Support Coordinator will also schedule a face-to-face meeting with you to answer questions, help you understand the system, explain your rights and develop a service plan based on your individual needs.

Is there any charge for ALTCS services?

For residents of an institution or a nursing facility, you will pay a Share of Cost, if you have any income or benefits. Any Share of Cost is determined by AHCCCS based on their criteria. The Department of Economic Security/Office of Accounts Receivable is responsible for collecting the Share of Cost. You will receive a monthly billing from the Office of Accounts Receivable if you have a Share of Cost.

If you have private insurance or Medicare, these insurance benefits must pay first before ALTCS money is used. ALTCS is the payer of last resort. Be sure to tell your Support Coordinator if you have other insurance.

What if I move out of state/out of the country?

Health and long term care services through ALTCS and the Division are limited to residents of the state of Arizona. If you are thinking about moving out of state or

out of country, contact your Support Coordinator. He/she can provide assistance in locating services and resources for the area to which you are moving. Keep in mind that eligibility requirements and covered services will vary from state to state.

What if I am out of state/out of country temporarily?

Health care services are limited to emergency care only when you are out of state temporarily (less than 30 days). Health care coverage is not available when you are out of the country. Please make sure you have enough medication prior to going out of state/country. It may be useful to call your health plan's Member Services before your trip to ensure you understand their procedure should an emergency occur.

What is the transitional ALTCS Program?

Even if you do not functionally qualify for ALTCS, you may still qualify for services through the transitional ALTCS program. AHCCCS also determines eligibility for this program. If you are eligible for the transitional ALTCS Program, you may receive the services listed in this booklet; however, there is a limitation on services received in institutional settings (e.g. Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded, etc.)

RIGHTS AND RESPONSIBILITIES

What are my rights?

Your Support Coordinator will give you a list of your rights and explain them to you.

What are my rights to services?

- You have the right to be treated with respect and with due consideration for your dignity and privacy.
- You will receive the services listed in your Individual Support Plan (ISP). Services must be medically necessary, cost effective and based on actual needs as shown by assessments.
- You have the right to participate in the development of your Individual Support Plan.
- You have the right to know about providers who speak languages other than English
- You can get interpreter services if you do not speak English or if you are hearing impaired, to help you get the services you need.

- You have the right to obtain materials and information, including this member handbook in alternative languages or formats. Contact your Support Coordinator if you need help finding a provider who is able to meet your cultural needs or obtaining materials in another language or format.

- You can get covered services without concern about race, ethnicity, national origin, religion, gender, age, mental or physical disabilities, sexual orientation, genetic information or ability to pay.

- You have the right to be free from any form of restrain or seclusion. Restraints or seclusion cannot be used as a means of coercion (to try to force you to do something). They also cannot be used for discipline, convenience, retaliation, or as specified in other federal or state regulation on the use of restraints and seclusion.

- You can get quality services that support your personal beliefs, medical condition and background in a language you understand.

- You have the right to take part in decisions regarding your care. This includes your right to refuse service or treatment.

- You have the right to be informed of the risks, benefits and consequences of treatment or non-treatment. You and your representative/guardian have the right to participate in any decisions related to medical care and treatment options.

- You can receive information on available treatment options and alternatives that are presented in a manner appropriate to your condition and your ability to understand.

- You have the right to get a second opinion from a qualified health care professional within the network, or have a second opinion arranged outside the health plan's network, only if there is not adequate in-network coverage, at no cost to you.

- You have the right to receive all critical services identified in your Individual Support Plan to help with bathing, dressing, toileting, feeding, transferring to and from your bed or wheelchair and other similar daily activities. You also have the right to participate in developing a back-up plan for any critical service provided in your home. This back-up plan will include steps and resources available to you when unplanned circumstances occur (e.g. regular caregiver is ill and unable to provide scheduled services). You may also call your Support Coordinator to help you receive these critical services.

What are my responsibilities?

- You must tell your Support Coordinator if your finances change and about any health insurance you have.

- You are responsible for keeping your current AHCCCS identification card. Make sure you present your current insurance card when receiving any health care services. When it is not valid it is your responsibility to destroy it. Any misuse of the card, including loaning, selling or giving it to others could result in loss of your eligibility as a member and/or in legal action.

Who has the right to see my records?

All information and records are confidential. However, all individuals who provide treatment to you can see your records as needed. They may also be shown to your responsible person or all others with your written consent. You may review your records at any time. You also have a right to receive a copy of your medical records free of charge.

As required by HIPAA, your access to psychotherapy notes may be denied. The Division recommends you contact the psychotherapist directly for these records.

FRAUD AND ABUSE

Your ALTCS benefits are provided based on your health and financial status. Your benefits may not be used by anyone else. Do not loan your health care card to anyone. If your card is lost or stolen, report it immediately to your Support Coordinator at the number noted inside the front cover of this handbook.

If you notice things like a provider billing for services you have not received or someone getting ALTCS benefits for which they are not eligible, you must report this to your Support Coordinator.

If you commit fraud, you may lose your benefits and legal action against you may be taken.

SERVICE DELIVERY

What does a Support Coordinator do?

Support Coordinators assess and coordinate your service needs. They work with you to arrange for services and to assist in identifying appropriate community resources. In addition they monitor how your services are provided.

Can I receive any services that are long term care services?

Services must be medically necessary, cost effective and based on actual needs as shown by assessments. You have the right to receive services as authorized. Many of the long term care services can be provided in your home.

Who will provide these services?

The Division will coordinate with an individual or an agency to provide services. You can choose a provider, if a choice is available. Call your Support Coordinator if you would like a copy of a provider directory for your area and a listing of providers who speak languages other than English. You may also obtain a list of providers via the Division's website **http://www.azdes.gov/ddd/**

The behavioral health services are provided through Regional Behavioral Health Authorities (RBHAs). Your Support Coordinator can let you know what agency or agencies serve your area.

Can any therapist or provider deliver ALTCS services?

No, all service providers must be certified by DES/Office of Licensing, Certification and Regulation and registered with AHCCCS. They must have a contract or individual provider agreement with the Division. A therapist must also maintain the appropriate and current professional license.

What long term services are covered?

You and your Support Coordinator will review all of your current evaluations to assess your needs. From this review, your Individual Support Plan (ISP) will be developed. Your Support Coordinator will coordinate services based on your ISP. The ISP will be reviewed regularly and can change as needed. Based upon medical need and within the Division rules, you may be authorized to receive one or more of the following services:

- Attendant Care (help with personal care and housekeeping);
- Augmentative Communication (devices to help in communication) (1);
- Behavioral Health (care for individuals with behavioral health needs);
- Day Treatment and Training (training, supervision and therapeutic activities to promote skill development in independent living, self care, communication and social relationships);

(1) These services require your insurance company to be billed first if you have private insurance or Medicare. ALTCS is payor of last resort.

- Extended Employment Services (provides training and ongoing supports to persons engaged in work);
- Habilitation (interventions such as habilitative therapies, special developmental skills, behavior intervention and sensory-motor development designed to increase functioning);
- Home Health Aide (health maintenance, continued treatment or monitoring of a health condition and supportive care with activities of daily living) (1) (2);
- Home Health Nurse (skilled nursing services) (1) (2);
- Homemaker (help with housecleaning);
- Home Modification (A service that provides physical modification to the home setting that enables the individual to function with greater independence and that has a specific adaptive purpose) (2);
- Hospice (care for terminally ill individuals) (1) (2);
- Non-Emergency Transportation (must be medically necessary and to or from another ALTCS service);
- Respite (short term care and supervision to relieve primary caregivers. The Division can authorize up to 720 hours per year based on your assessed need); and/or
- Support Coordination (coordination of services).

What residential options may be available?

The Division provides services in a variety of community living environments. Some residential opportunities may be available for individuals to choose from that are aided by supports put in place within their communities. These services are not an entitlement or right. ALTCS services do not include Room and Board in these settings. You will be billed for Room and Board based upon the amount of your monthly benefits (e.g. SSI, Social Security, VA, or other benefits).

(1) These services require your insurance company to be billed first if you have private insurance or Medicare. ALTCS is payor of last resort.

(2) These services must be prior authorized by your Primary Care Provider (PCP).

Options include:

Adult Developmental Home: An alternative residential setting for individuals 18 years or older. This setting provides room and board, supervision and coordination of habilitation for up to three people.

Child Developmental Foster Home: An alternative residential setting for children up to 18 years old. This setting provides supervision and coordination of habilitation for up to three children.

Group Home: A community residential setting for up to six people. It is licensed by Department of Health Services to provide room and board, supervision and habilitation. The Group Home provides a safe, homelike, family atmosphere, which meets the physical and emotional needs of individuals who cannot physically or functionally live independently in the community.

Nursing Facility: A Medicare/Medicaid certified facility which provides inpatient room and board and nursing services to individuals who require these services on a continuous basis, but who do not require hospital care or direct daily care from a physician.

Intermediate Care Facility for the Mentally Retarded (ICR/MR): A facility that provides health, habilitative and rehabilitative services to individuals who require services on a continuous basis.

What long term care services are not covered?

All long term care services must be authorized before they are provided. Any services not authorized are not covered.

BEHAVIORAL HEALTH

How do I get behavioral health services?

You may apply on your own or seek assistance from your Support Coordinator or Primary Care Provider (PCP). The Regional Behavioral Health Authority (RBHA) will determine which behavioral health services you will receive.

How do I contact the Regional Behavioral Health Authority (RBHA) that serves my county?

If you have questions regarding behavioral health services, call your local RBHA. The names and telephone numbers of the local RBHAs are:

Magellan (Maricopa County)

Information & Referral .... **Toll-free 800-564-5465**

Crisis Phone Line ..... 602-222-9444 or **toll-free 800-631-1314**

Community Partnerships of Southern Arizona (Cochise, Graham, Greenlee, Pima, and Santa Cruz counties)

Information & Referral .... 520-318-6946 or **toll-free 800-771-9889**

Crisis Phone Line ..... 520-622-6000 or **toll-free 800-796-6762** (Pima Co.)
Toll-free 800-586-9161 (Cochise, Graham, Greenlee, and Santa Cruz counties)

Northern Arizona Regional Behavioral Health Authority (Apache, Navajo, Coconino, Mohave and Yavapai counties)

Information & Referral .... 928-774-7128 or **toll-free 800-640-2123**

Crisis Phone Line ..... **Toll-free 877-756-4090**

Cenpatico Behavioral Health of Arizona (Gila, La Paz, Pinal, and Yuma counties)

Information & Referral .... 480-982-1317 or **toll-free 866-495-6738**

Crisis Phone Line ..... **Toll-free 866-495-6735**

What if this is an emergency?

If you are in a crisis situation and think you might hurt yourself or someone else, please call 911 or the Crisis Phone Line listed above for your local RBHA.

What behavioral health services are covered?

Your Support Coordinator can answer your questions and provide information about behavioral health services. The following behavioral health services are covered:

- Behavior Management (behavioral health personal assistance, family support, peer support)
- Behavioral Health Case Management Services
- Behavioral Health Nursing Services
- Behavioral Health Therapeutic Home Care Services (formerly known as Therapeutic Foster Care)
- Emergency/Crisis Behavioral Health Care
- Emergency and Non-Emergency Transportation
- Evaluation and Assessment
- Group Therapy and Counseling

- Individual Therapy and Counseling
- Family Therapy and Counseling
- Inpatient Hospital Services
- Non-Hospital Inpatient Psychiatric Facilities (residential treatment centers and sub-acute facilities)
- Institutions for Mental Disease (with limitations)
- Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
- Opioid Agonist Treatment
- Partial Care (supervised day program, therapeutic day program and medical day program)
- Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
- Psychotropic Medication
- Psychotropic Medication Adjustment and Monitoring
- Respite Care (with limitations)
- Rural Substance Abuse Transitional Agency Services
- Screening

MANAGED CARE

What is Managed Care?

Managed Care is a system of health care. A managed care organization is usually called a health plan. Health plans contract with a group of health care providers such as physicians, hospitals, clinics, therapists, dentists, pharmacies and others.

Is there an incentive plan for physicians?

Federal law allows health plans to provide incentive plans for physicians. This means “any compensation arrangement between a Managed Care Organization (health plan) and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare beneficiaries or Medicaid recipients enrolled in the Managed Care Organization.”

If you want to know what incentive plans your physician has or any of the contract terms, you may request this information. For example, you may request:

- Whether your health plan has physician incentive plans that affect the use of referral services;
- The type of compensation arrangements the plan uses, e.g., bonus, withholding;
- Whether stop-loss insurance is provided to the physician incentive plan; and
- A summary of any member survey results.

Contact your health plan at the number noted in your "Health Plan Member Handbook" to obtain the above information.

No specific payment of any kind may be made directly or indirectly under the incentive plan to a physician or physician group as an inducement to reduce or limit covered medically necessary services furnished to a member.

HEALTH AND MEDICAL SERVICES

What are health and medical services?

Health and medical services are also known as acute care services that either maintain or restore good health. The services must be medically necessary and cost effective. They are provided through your Primary Care Provider (PCP). Your PCP may refer you to a specialist, if appropriate. Contact your Division Support Coordinator if you need assistance in coordinating care and services.

What is a Primary Care Provider?

A Primary Care Provider (PCP) is your health plan physician. The PCP approves your medical care, makes referrals to specialists and orders appropriate services such as therapy, medications, durable medical equipment, home health nursing or home health aid.

How do I get a Primary Care Provider?

Your Support Coordinator will contact you once you are enrolled in ALTCS. Once you choose a health plan, you will need to choose a Primary Care Provider. If you do not choose a Primary Care Provider within 10 calendar days, the health plan will assign one for you. You can request a change of your PCP by contacting your health plan member services representative.

How do I get to see my Primary Care Provider?

Call your physician's office to make an appointment. Please refer to your "Health Plan Member Handbook" or your "Fee for Service Handbook" for further information.

How do I make, change or cancel an appointment with my Primary Care Provider?

Call your physician's office ahead of time when you cannot keep your appointments. When possible, schedule appointments with your doctor instead of using urgent care or the emergency room.

Do I have to go through my Primary Care Provider for services?

Yes, except for emergencies, behavioral health services, dental services and transportation. If you are under 21 years of age, you may use dental services directly from a dentist. Check with your health plan for coverage and a list of available dentists. If you need transportation to a medical appointment, please refer to your "Health Plan Member Handbook" or "Fee for Service Handbook."

You can get behavioral health services from your local Regional Behavioral Health Authority (RBHA). You do not need a referral from your Primary Care Provider for behavioral health services. However, your PCP may be able to help you if you have depression, anxiety or attention deficit disorder.

In addition, if you are female, you do not need a referral from your Primary Care Provider to obtain preventative and routine services from gynecology providers within your health plan's network.

What if I want to see a physician who is not on the health plan?

You can choose your physicians, but if you use a physician that is not on the ALTCS health plan, you will be responsible for costs. If you have private health insurance, including Medicare, check on the plan's coverage for medical costs.

If I qualify, can I use Medicare for my medical insurance?

Yes, Medicare is medical insurance. If you are using Medicare as your medical insurance, you may receive additional services. Refer to your "Medicare and You" handbook. Call 1-800-MEDICARE (1-800-633-4227) for a copy. Be sure to let your health care providers and your Support Coordinator know if you have Medicare.

If you are ALTCS eligible and have Medicare, most of your prescription drugs will be covered through your Medicare Advantage or Medicare Prescription Drug Plan.

There are certain medications that will continue to be covered by your ALTCS Health Plan or through the Regional Behavioral Health Authority. If you have questions or need assistance, please contact your Support Coordinator.

What if I receive a bill?

Contact the physician's office to make sure they have the current health insurance cards. If you continue to get bills, contact the health plan's Member Services. Your Support Coordinator may also be able to assist you.

What if I am eligible for Children's Rehabilitative Services (CRS)?

If you are eligible, you will be referred to these services before you use services provided by the Division or your health plan.

What health and medical services are covered?

The following list of health and medical services are covered. There may be exclusions or limitations on some services depending upon whether you are over 21 years of age. Your "Health Plan Member Handbook" or your "Fee for Service Handbook" will tell you more about each service.

- Ambulatory Surgery
- Anti-hemophilic Agents and Related Services
- Audiology
- Behavioral Health
- Chiropractic Services
- Dialysis
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention
- Emergency Services
- Family Planning
- Hospital Services
- Immunizations
- Incontinence Supplies (for individuals 3—21 years of age under certain circumstances)
- Laboratory
- Maternity Services
- Medical Foods

- Medical Supplies, Durable Medical Equipment (DME), Orthotic and Prosthetic Devices
- Medically-necessary Pregnancy Termination
- Nutrition
- Oral Health
- Physician Services
- Podiatry
- Post-stabilization Care Services
- Prescription Medications
- Preventive and Pre-natal HIV Testing and Counseling
- Primary Care Provider (PCP) Services
- Radiology and Medical Imaging
- Rehabilitation Therapy
- Respiratory Therapy
- Transplantation of Organs and Tissue and Related Immuno-suppressant Drugs
- Transportation
- Triage/Screening and Evaluation
- Vision Services/Opthalmology/Optometry

What is EPSDT?

Early and Periodic Screening, Diagnosis and Treatment. This program provides comprehensive health care service through primary prevention, early intervention, diagnosis and medically necessary treatment from birth to age 21. Included are a comprehensive history, developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screening and immunizations. EPSDT provides for all medically necessary services to treat a physical or mental illness discovered in the process.

How can I obtain transportation?

First find out if there is a relative, friend or neighbor who can give you a ride. If you do need a ride, call your health plan's Member Services at least *three business days* in advance for a non-urgent medical appointment. If you have an urgent need to see your doctor, call Member Services *three hours* before your appointment to arrange a ride. If you do not call ahead of time to make arrangements, the health plan may not have enough time to arrange transportation and you may end up having to reschedule your appointment.

When you call to arrange for a ride, let Member Services know of any special needs you have such as a car seat or wheelchair. After your appointment, call Member Services for a ride home. In addition, if you cancel your appointment, don't forget to call Member Services and cancel your ride. For further information and tips on arranging transportation, see your "Health Plan Member Handbook"

Transportation is generally limited to you and a caregiver who can assist you during your medical appointment. Parents should make alternative care arrangements for siblings.

If this is an emergency, call 911 or the emergency number in your area.

What services are not covered?

Not all services are covered. Some services not covered include:

- Cosmetic Surgery (surgery to change the way you look);
- Prescription and Medical Supplies not ordered by your physician;
- Hearing Aids and Eyeglasses for adults

EMERGENCY SERVICES

What do I do in case of an emergency?

Emergency care is available 24 hours a day, 7 days a week. If you need emergency care, call your physician or the number in your "Health Plan Member Handbook" for information on what to do and where to go for care. If it is a life-threatening emergency, call 911 or the emergency number for your area. You may also go to the nearest emergency room (ER) for help.

Emergency services are those health services that are required for relief of severe pain or treatment of a sudden medical condition which, if not immediately treated, would lead to a disability or death. Minor problems such as flu, colds, sore throats, etc., are not emergencies. Hospital emergency rooms should be used for life threatening situations only.

For further information see your "Health Plan Member Handbook".

ADVANCE DIRECTIVES

What are Advance Directives?

You have the right to participate in decisions regarding your health care. There may be a time, however, when you are so ill that you cannot make decisions about your health care. If this happens, Advance Directives are written statements about what health care, if any, you will accept. You can also name someone to make these decisions on your behalf.

There are four types of Advance Directives: A Living Will, a Medical Power of Attorney, a Mental Health Care Power of Attorney and a Pre-Hospital Medical Directive. Refer to your "Health Plan Member Handbook" for further information regarding these documents. You should get help writing Advance Directives. Ask your doctor for help if you are not sure who to call.

MEDIATION

What is mediation?

Mediation is a process for resolving disagreements without a grievance and appeal process. It is an informal process involving a mediator.

What is the mediator's role?

Mediators are trained neutral volunteers who help define issues and guide the communication process so that a mutual agreement can be reached. The mediator may offer suggestions and help develop options to resolve issues, but the participants make the final agreement. In order for mediation to be effective, all participants must want to resolve the issues and be willing to work toward that goal.

Is mediation confidential?

Yes, the mediators and participants will not disclose information from the mediation meeting.

Do I need a lawyer?

Mediation is not a substitute for legal advice. If you retain a lawyer, be advised that your lawyer may not directly participate in mediation.

How long does mediation take?
Mediation meetings are normally two hours in length and may range from one to three sessions, depending on the complexity of the issues.

What is a mediation agreement?
When participants agree on a solution, an agreement is written by the mediators and signed by all participants. The agreement is a written plan of action where each party has clearly defined the steps necessary to resolve the conflict. Mediation agreements are typically more creative and mutually acceptable than a finding made by a grievance or a hearing officer.

How do I request mediation?
Inform your Support Coordinator, or call the Division mediation coordinator at 602-542-0419, outside of Maricopa county call **toll-free 866-229-5553**.

GRIEVANCES, APPEALS AND REQUEST FOR FAIR HEARING

What is a Grievance?
A “Grievance” is a statement of dissatisfaction of services.

How do I file a Grievance?
You can call or write a letter to the District Program Manager for the area in which you live. You may also contact the Division’s Consumer and Family Support Unit at 602-542-0419 or outside Maricopa County 1-866-229-5553.

How long will the grievance process take?
A decision should be made within 90 calendar days from Division’s receipt of your grievance.

What is a Notice?
A “Notice” is a written statement that tells you what action the Division or your ALTCS Health Plan is going to take. A Notice also provides you with your rights to appeal.

If you do not understand the Notice or do not think the explanation provided is adequate, you may contact the Division’s Office of Compliance and Review at 602-542-0419 or 866-229-5553 (outside Maricopa County) and ask for a review of the Notice. The Division will review your complaint, and issue an amended Notice,

if needed. If you receive a revised Notice and still do not believe the explanation is adequate, you may file a second complaint with the Division's Office of Compliance and Review. If the Division is unable to resolve this issue to your satisfaction, you may also file a complaint with the AHCCCS Division of Medical Management.

What is an Action?

An "Action" by the Division of Developmental Disabilities means:

- The denial or limited authorization of a service you have requested, including the type and level of service;
- The reduction, suspension, or termination of an existing service;
- The denial of payment for a service, either all or in part;
- The failure to provide services in a timely manner;
- The failure to act within certain timeframes for grievances and appeals;
- The denial to obtain a health care service outside the Division's network if you live in a rural area.

How do I request an appeal?

If you, or people acting on your behalf, including your doctor or provider, disagree with the Division's action, you may file an appeal. You may do this by calling the Division's Office of Compliance and Review at 602-542-0419 or outside Maricopa County call 866-229-5553 and present your appeal orally.

Will my services continue during the appeal process?

You are entitled to continue receiving services during the appeal process if:

- Your appeal involves a termination or reduction of the service you are currently receiving;
- The service you are receiving was authorized by the Division;
- The original authorization for the service you are receiving has not expired;
- You request that the service continue; and
- You file the appeal before the intended date of reduction/termination, or you request the appeal within 10 calendar days of the mailing of the notice, whichever is later.

How long will my services continue?

You will continue to receive your services until any one of the following occurs:

- You withdraw the appeal;
- You do not request a hearing 10 calendar days from the date the Division sent you the appeal decision or do not request that the services continue when you are requesting a hearing;
- AHCCCS issues a hearing decision against you; or
- The time limits of a service authorization have been met.

How long will the appeal process take?

The Division will investigate the appeal and make a final written decision within 30 calendar days. If the Division needs additional investigation time, you will be asked for an extension.

What do I have to say in my request for a hearing with AHCCCS?

The written request for a hearing must state the issue that is being appealed to AHCCCS.

ACRONYMS / ABBREVIATIONS

AHCCCS: Arizona Health Care Cost Containment System - This agency administers Arizona's Medical programs.

ALTCS: Arizona Long Term Care System - This program is administered by AHCCCS and provides long term and acute medical services to eligible individuals based on documented needs.

CRS: Children's Rehabilitative Services – These health and medical services are provided through the Arizona Department of Health Services. Services are limited to individuals 21 years of age or younger with certain qualifying conditions or diagnoses.

DES: Department of Economic Security - This is the State agency overseeing the Division of Developmental Disabilities.

DIVISION: Division of Developmental Disabilities (DDD) - The division of DES that is responsible for providing services to ALTCS eligible individuals who have a developmental disability.

DME: Durable Medical Equipment - This necessary equipment is used over time and is not thrown away e.g. wheelchairs, ventilators, braces, etc.

DUAL ELIGIBLE: An individual who is eligible for both Medicare and Medicaid (AHCCCS/ALTCS).

EPSDT: Early and Periodic Screening, Diagnosis and Treatment - The Division provides these comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment.

HIPAA: Health Insurance Portability and Accountability Act. The federal law that describes how your protected health information may be used and disclosed and how you can get access to this information.

ISP: Individualized Support Plan. This is a process that includes a review of assessments and evaluations; determination of services needed; setting of goals and objectives and development of strategies to meet those objectives. A team including the person supported, responsible person, Support Coordinator and others develop the ISP as appropriate. The ISP guides service delivery and includes a process for monitoring the quality and effectiveness of services.

MEDICAID: See TITLE XIX.

PCP: Primary Care Provider - This is the physician who is responsible for all the health needs of the individual. The PCP orders certain services and refers individuals to specialists.

RBHA: Regional Behavioral Health Authority – These regional agencies are contracted with the Arizona Department of Health Services to provide behavioral services to individuals who are AHCCCS/ALTCS eligible.

TITLE XIX: This is a section of the Social Security Act created in 1965. It helps states in providing medical and long term care services to individuals who are blind, have a disability or are age 65 or older and who meet certain income requirements.